

SERVICE STANDARD
INDIANA DEPARTMENT OF CHILD SERVICES
COUNSELING

I. Service Description

- A. This service standard applies to services provided to families and children involved with the Department of Child Services and/or Probation.
- B. These services include the provision of structured, goal-oriented therapy for families affected by physical abuse, sexual abuse, emotional abuse, or neglect.
 - 1. In addition, this service can address other issues, such as:
 - a. Substance use abuse
 - b. Mental health issues
 - c. Dysfunctional family of origin dynamics
 - d. Youth behavioral issues that resulted in the involvement of the Department of Child Services and/or Probation
- C. Professional staff provides individual, group, and/or family counseling with emphasis on one or more of the following areas:
 - 1. Initial assessment
 - 2. Conflict resolution
 - 3. Behavior modification
 - 4. Grief loss/separation
 - 5. Trauma
 - 6. Sexual issues including those related to development and behaviors
 - 7. Identify systems of support
 - 8. Interpersonal relationships
 - 9. Communication skills
 - 10. Substance abuse awareness/family dynamics
 - a. Substance abuse Counseling/Treatment must be done under the Service Standard “Substance Abuse Treatment” due to the specific legal qualifications of the provider, not under this counseling service standard
 - 11. Parenting skills
 - 12. Anger management
 - 13. Supervised therapeutic visits
 - a. Supervised Visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard.
 - b. The Individual and Monthly Visitation Reports must be used to document the supervised visitation portion of the services provided.
 - c. The Monthly Progress Report will be used to document other services provided within this service standard.

- d. Further instructions on how to facilitate, document, and bill for the visitation is outlined in the Visitation Facilitation Service Standard.
 - (1) Specifically, Section II (Service Delivery Referral Process), Section VI (Billable Units), and Section X (Required Training).
- 14. Problem solving
- 15. Anxiety/Stress management
- 16. Goal-setting
- 17. Domestic violence issues
- 18. School problems
- 19. Family of origin/inter-generational issues
- 20. Sexual abuse – victims and caretakers of sexual abusers

II. Service Delivery

- A. Service Settings:
 - 1. For services billable to DCS, services are provided face-to-face in the counselor's office or limited services may be provided in other structured settings (ie school office, DCS office) to maintain confidentiality and privacy.
 - 2. For services billable to Medicaid Clinic Option, the service setting is either outpatient or office setting
- B. Services to include a Bio-psychosocial assessment with the following domain to assess the client's strengths and needs:
 - 1. Life Domain
 - a. Education level
 - b. Employment history and current status
 - c. Financial status
 - d. Housing history and current arrangement
 - e. Criminal history
 - f. Military
 - 2. Health Domain
 - a. Prior treatment and hospitalization
 - b. Current physical and mental diagnosis
 - c. Current symptoms
 - d. Current prescribed medications
 - e. Substance Use Screening Tool
 - (1) UNCOPE or CAGE
 - (2) Substance Abuse and Mental Health Services Administration
 - (3) (SAMHSA): www.nrepp.samhsa.gov
 - 3. Trauma Domain
 - a. Client history of childhood trauma
 - b. How trauma has impacted life functioning

- c. Prior child welfare involvement
 - 4. Family Domain
 - a. Family safety and well-being
 - b. Domestic violence risk indicators
 - c. Parental capacities
 - d. Family structure and customs
 - e. Functional strengths
 - f. Family functioning and stability
 - 5. Community Domain
 - a. Utilization and access to resources
 - b. Access to transportation
 - c. Essential connections
- C. Services will be based on objectives derived from the family's established DCS/Probation case plan, Informal Adjustment, taking into consideration the recommendations of the Child and Family Team (CFT) and authorized by DCS/Probation referral, and subsequent written documents.
- D. The counselor will be involved in Child and Family Team Meetings (CFTM) if invited.
- E. Counselor must respect confidentiality.
 - 1. Failure to maintain confidentiality may result in immediate termination of the service agreement.
- F. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, lifestyle choices, as well as complex family interactions
 - 1. Services will be delivered in a neutral valued, culturally competent manner
- G. Services include providing any requested testimony and/or court appearances, including hearings and/or appeals.
- H. Services must be provided as a time convenient for the family
- I. Services will be time-limited
- J. Services must include on-going risk and safety assessment and monitoring client's progress.
 - 1. A re-assessment of the family's risks, needs, and goals shall be completed minimum of every 90 days, while updating the treatment plan as appropriate.
 - 2. Agency shall provide DCS/Probation with a copy of the updated treatment plan every 90 days.
 - 3. Treatment plan shall be reviewed with the client at a minimum of every 30 days.
- K. Written reports will be submitted monthly to provide updates on progress and recommendation for continuation or discontinuation of treatment.
 - 1. DCS Monthly Progress Report will be used.

III. Target Population

- A. Services must be restricted to the following eligibility categories:
 - 1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment or CHINS status.
 - 2. Children and their families which have an IA or the children have a status of CHINS and/or JD/JS.
 - 3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
 - 4. All adopted children and adoptive families.
 - 5. Services billable to MRO are for Medicaid eligible clients with a qualifying diagnosis and level of need.
 - 6. Services billable to MCO are for Medicaid eligible clients.

IV. Goals and Outcomes

- A. Goal #1: Timely Engagement and assessment of clients' strengths and needs.
 - 1. Therapist to make face to face contact with client within 5 days upon receipt of referral.
 - a. Outcome Measure 1: 95% of all clients will have face to face contact within 5 days of receipt of the referral.
 - b. Outcome Measure 2: 95% of unsuccessful contacts must be notified to Family Case Managers and/or Probation Officers within 48 hours of initial attempts.
 - 2. Therapist to complete biopsychosocial assessment
 - a. Outcome Measure 1: 95% of all clients will have a complete Biopsychosocial within 14 days of initial contact.
 - b. Outcome Measure 2: 95% of all assessments will be sent to the Family Case Manager within 7 days of completion of assessment.
 - 3. Therapist to develop **initial** treatment plan, to include crisis intervention and safety planning.
 - a. Outcome Measure 1: 95% of all clients will have developed initial treatment plan with family within 7 days of initial face to face contact.
 - b. Outcome Measure 2: 95% of all clients' initial treatment plan must be sent to the current Family Case Manager and/or Probation Officer within 14 days of initial contact.
- B. Goal #2: Provide timely, consistent, structured goal-oriented, as indicated on the treatment plan.
 - 1. Therapist shall provide time-limited, specific therapeutic modality to address objectives as identified on treatment plan and consistent with DCS Case Plan. Therapist or backup is available for crisis intervention to the family 24/7 by phone or in person.
 - a. Outcome Measure 1: A plan will be developed to address any presenting crises that present during the referral time period.

2. Therapist shall updated treatment plans every 90 days.
 - a. Outcome Measure 1: 95% of all clients will have updated treatment plans with short and long term measureable goals consistent with DCS Case Plan.
 - b. Outcome Measure 2: 95% of all clients will meet with therapist to review goals, update, and sign updated treatment plans with specific recommendations for continuation of services every 30 days.
 - c. Outcome Measure 3: 95% of families will have a written treatment plan prepared and sent to the current Family Case Manager/Probation Officer within 7 days revised and updated treatment plans.
 3. Therapist shall prepare detailed monthly written summary reports and sent to the current Family Case Manager/Probation Officer.
 - a. Outcome Measure 1: 100% of all families will have Monthly reports, due by the 10th of each month following the month of service, case documentation shall show when report is sent.
- C. Goal #3: Improved family functioning including development of positive means of managing crisis.
1. Service delivery is grounded in best practice strategies, using such approaches as cognitive behavioral strategies, motivational interviewing, change processes, and building skills based on a strength perspective to increase family functioning.
 - a. Outcome Measure 1: 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
 - b. Outcome Measure 2: 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of 'substantiated' abuse or neglect throughout the service provision period (to be measured/evaluated by DCS/Probation staff)
 - c. Outcome Measure 3: 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
- D. Goal #4: DCS/Probation and clients will report satisfaction with services provided.
1. Outcome Measure 1: DCS/ Probation satisfaction will be rated at 4 and above on the Service Satisfaction Report.
 2. Outcome Measure 2: 90% of the clients will rate the services 'satisfactory' or above on a satisfaction survey developed by the service provider, unless DCS/Probation distributes one to providers for their use with clients.

- a. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

V. Minimum Qualifications

A. MCO Billable

1. Medical doctor, doctor of osteopath; licensed psychologist
2. Physician or HSPP-directed services provided by the following:
 - a. Licensed clinical social worker
 - b. Licensed marital and family therapist
 - c. Licensed mental health counselor
 - d. Person holding a master's degree in social work, marital and family therapy or mental health counseling; and advanced practice nurse

B. MRO Billable

1. Providers must meet either of the following qualifications:
 - a. Licensed professional, except for a licensed clinical addictions counselor
 - b. Qualified Behavioral Health Professional (QBHP)

C. DCS Billable:

1. Counselors/therapists under this standard must meet one of the following minimum qualifications:
 - a. Master's or Doctorate degree with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
 - b. Master's Degree with a temporary permit issued by the Indiana Behavioral Health and Human Services Licensing Board
 - c. Master's degree in a related human service field and employed by an organization that is nationally accredited by the Joint Commission, Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities. That individual must also:

- (1) Complete a minimum of 24 post-secondary semester hours or 36 quarter hours in the following coursework:
 - (a) Human Growth & Development
 - (b) Social & Cultural Foundations
 - (c) Group Dynamics, Processes, Counseling and Consultation
 - (d) Lifestyle and Career Development
 - (e) Sexuality
 - (f) Gender and Sexual Orientation
 - (g) Issues of Ethnicity, Race, Status, and Culture
 - (h) Therapy Techniques
 - (i) Family Development and Family Therapy
 - (j) Clinical/Psychiatric Social Work
 - (k) Group Therapy
 - (l) Psychotherapy
 - (m) Counseling Theory & Practice
- d. Individual must complete the Human Services Related Degree Course Worksheet.
 - (1) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.
 - (2) Transcripts must be attached to the worksheet.
- e. Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in 1 (a and b) above.

D. Supervisor

1. Master's or Doctorate Degree in Social Work, Psychology, or Marriage and Family or related Human Services field, with a current license issued by the Indiana Behavioral Health and Human Services Licensing Board
2. Supervision/consultation is to include:
 - a. Not less than one (1) hour of face-to-face supervision/consultation per 20 hours of direct client services provided
 - b. Nor occur less than every two (2) weeks
3. Providers are to respond to the on-going individual needs of staff by providing them with the appropriate combination of training and supervision.
 - a. The frequency and intensity of training and supervision are to be consistent with 'best practices' and comply with the requirements of each provider's accreditation body.

- b. Supervision should include the individual, group, and direct observation modalities and can utilize teleconference technology.
- 4. In addition to the above:
 - a. Knowledge of:
 - (1) child abuse and neglect
 - (2) Child and adult development
 - (3) Community resources
 - (4) Ability to work as a team member
 - b. Belief in:
 - (1) Helping clients change their circumstances, not just adapt to them
 - (2) Adoption as a viable means to build families
 - c. Understanding regarding issues that are specific and unique to adoption such as:
 - (1) Loss
 - (2) Mismatched expectations and flexibility
 - (3) Entitlement
 - (4) Gratification delaying
 - (5) Flexible parental roles
 - (6) Humor

VI. Billable Units

- A. Medicaid
 - 1. It is expected that the majority of the individual, family, and group counseling provided under this standard will be based in the clinic setting.
 - 2. Some group counseling may occur in the community
 - a. These units may be billable through MRO
 - b. Medicaid shall be billed when appropriate
 - 3. Service through the MCO may be Outpatient Mental Health Services
 - a. Medicaid shall be billed first for eligible services under covered evaluation and management codes
 - (1) Including those in 9000 range
 - 4. Services through the Medicaid Rehab Option (MRO) may be:
 - a. Group Behavioral Health
 - b. Counseling
 - c. Therapy

Billing Code	Title
H0004 HW U1	Behavioral health counseling and therapy (group setting), per 15 minutes
H0004 HW HR U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, with consumer present)

H0004 HW HS U1	Behavioral health counseling and therapy, per 15 minutes (family/couple, group setting, without consumer present)
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B. DCS Funding

1. Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior or healthcare needs of the eligible client will be billed to DCS per face-to-face hours:
 - a. Face-to-face time with client (Individual and Family each have face-to-face rate)
 - (1) Members of client family are to be defined in consultation with the family and approved by DCS.
 - (a) This may include persons not legally defined as part of the family
 - b. Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed
 - c. Includes crisis intervention and other goal-directed interventions via telephone with the identified client family
 - d. Includes Child and Family Team Meetings or case conferences including those via telephone
 - (1) Initiated or approved by DCS/Probation for purposes of goal-directed communication
 - (2) Regarding services to be provided to the client/family

C. Supervised Visit:

1. Time spent facilitating a supervised visit will be billed separately from other services provided in the Service Standard
2. Services provided during facilitated supervised visits must fall within the scope of this Service Standard
3. The Supervised Visitation rate will be the same as the Counseling face-to-face rate
 - a. Will include only time spend directly supervising the visit
4. Any other billable time as defined in the Counseling face-to-face rate should be billed under the face-to-face rate

D. Per Person Per Group Hour

1. Services include group goal directed work with clients
2. To be billed per client per hour attended
3. Services may be billed in 15 minutes increments
 - a. Partial units are rounded to the nearest quarter hour using the following guidelines:
 - (1) 0-7 minutes – Do not bill (0.00 hour)

- (2) 8-22 minutes – 1 fifteen minute unit (0.25 hour)
- (3) 23-37 minutes – 2 fifteen minute units (0.50 hour)
- (4) 38-52 minutes – 3 fifteen minute units (0.75 hour)
- (5) 53-60 minutes – 4 fifteen minute units (1.00 hour)

E. Interpretation, Translation, and Sign Language Services

- 1. The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
- 2. If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
- 3. The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service. Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
- 4. The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
- 5. Certification of the Interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.

F. Court

- 6. The provider of this service may be requested to testify in court.
- 7. A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
- 8. If the provider appeared in court two different days, they could bill for 2 court appearances.
 - a) Maximum of 1 court appearance per day.
- 9. The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.

G. If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid.

- 1. A referral for 'Reports' must be issued by DCS in order to bill

VII. Medicaid

- A. For those families and children not eligible for Medicaid Rehabilitation Option, this service will be paid by DCS.
- B. For eligible families and children, some services may be provided through Medicaid Rehabilitation Option (MRO) with the remaining services paid by DCS.
- C. While the primary focus of these services is on the needs of the family, it is expected that some of these services will be deemed medically necessary to meet the behavioral healthcare needs of the MRO eligible client, and therefore may be billable to MRO.
- D. The service standard is not a Medicaid standard and includes services that are not billable to Medicaid.
- E. It is the responsibility of the contracted service provider to be knowledgeable about the Medicaid billing requirements and comply with them.
 - 1. Including Provider Qualifications
 - 2. Including Pre-Authorization
 - 3. Appropriately bill services in cases where they are Medicaid reimbursed
- F. Services not eligible for MRO may be billed to DCS

VIII. When DCS is not paying for services

- A. A billable unit of "Reports" has been developed for providers who service DCS families without DCS payment for these services (Medicaid, insurances, self-pay) but DCS wants a report from the provider on the progress of the family.
- B. The referral process has been set up to authorize reports and court components on the DCS referral form in these incidences.
- C. DCS will only pay for reports when DCS is not paying for these services.
- D. If the services provided are not funded by DCS, the report rate per hour will be paid for the necessary reports on a referral form issued by DCS.
- E. Court testimony will be paid per appearance if requested on a referral form issued by DCS.
 - 1. In order to be paid for a court appearance a subpoena or written request from DCS should be onfile.

IX. Case Record Documentation

- A. Case record documentation for service eligibility must include:
 - 1. A completed, and dated DCS/ Probation referral form authorizing services
 - 2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.

3. Safety issues and Safety Plan Documentation
4. Documentation of Termination/Transition/Discharge Plans
5. Treatment/Service Plan

X. Service Access

- A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.
- B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.
- C. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.
- D. Providers must initiate a re-authorization for services to continue beyond the approved period.

XI. Adherence to DCS Practice Model

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.
- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XII. Interpretation, Translation, and Sign Language Services

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing- impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio- cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.

- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

XIII. Trauma Informed Care

A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA

(<http://www.samhsa.gov/nctic/>):

1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
 2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"
 3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
 4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
 2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
 3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIV. Training

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training requirements, documents, and resources are outlined at:
<http://www.in.gov/dcs/3493.htm>
 - 1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
 - 2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
 - 3. Review the **Training Requirement Checklist and Shadowing Checklist** for expectations within each module.

XV. Adherence to DCS Practice Model

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.
- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XVI. Cultural and Religious Competence

- A. Provider must respect the culture of the children and families with which it provides services.
- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.
 - 1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
 - 2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
 - 3. The guidebook can be found at:
<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>

- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XVII. Child Safety

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
 - 1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
 - 2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.
- D. Must incorporate DCS Case Plan Goals and Child Safety goals.
- E. Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
- F. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.
 - a) Provider recommendations to modify the service/ treatment plan
 - b) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
- 3. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
- 4. When applicable Progress/Case notes may also include:

- a) Service/Treatment plan goal addressed (if applicable-
- b) Description of Intervention/Activity used towards treatment plan goal
- c) Progress related to treatment plan goal including demonstration of learned skills
- d) Barriers: lack of progress related to goals
- e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
- f) Collaboration with other professionals
- g) Consultations/Supervision staffing
- h) Crisis interventions/emergencies
- i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
- j) Communication with client, significant others, other professionals, school, foster parents, etc.
- k) Summary of Child and Family Team Meetings, case conferences, staffing

5. Supervision Notes must include:

- a) Date and time of supervision and individuals present
- b) Summary of Supervision discussion including presenting issues and guidance given.